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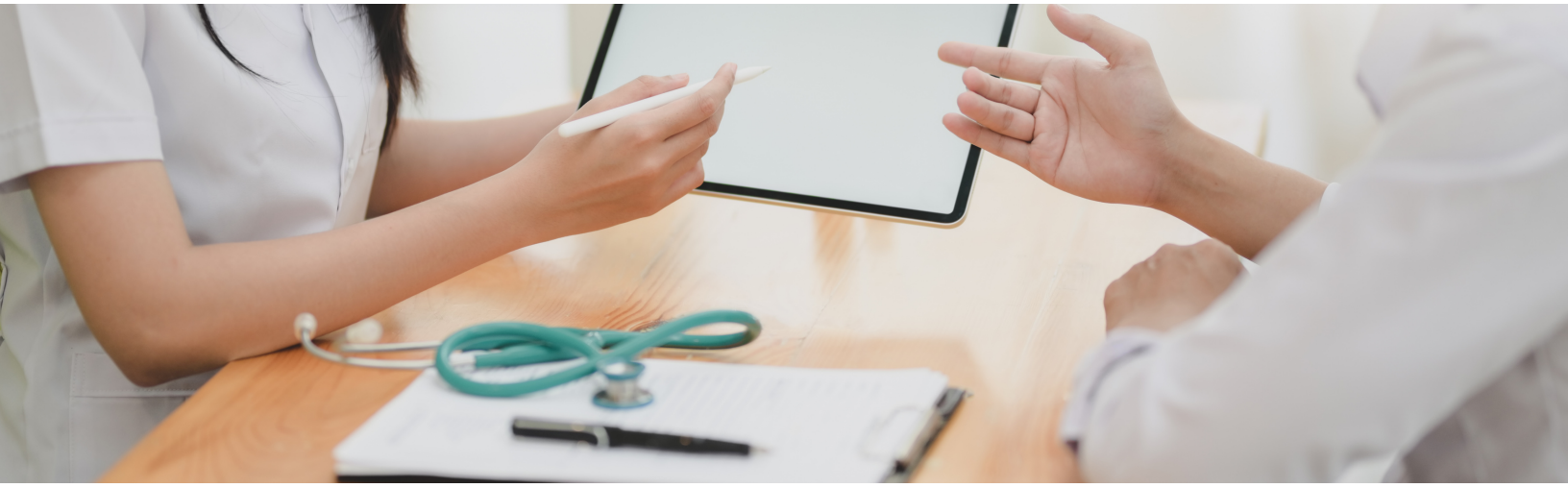
# PSLL MONTHLY NEWSLETTER

*Patient Safety Learning Lab*
*Division of General Internal Medicine | Brigham and Women's Hospital*



## About

### The Quality & Safety Dashboard

The Quality and Safety Dashboard is an Epic-integrated tool that enables clinicians to proactively identify quality & safety risks for patients in real-time. Patient data is gathered from various siloed parts of the EHR and placed in one convenient display.

The Dashboard aims to provide clinical decision support, improve interdisciplinary conversations regarding patient safety concerns, and facilitate compliance with key institutional priorities across Brigham Health.

## OVERVIEW

# The Quality & Safety Dashboard consists of six primary columns:

- Discharge Safety
- Advanced Care Planning
- Central Line
- Urinary Catheter
- VTE Prevention
- Diagnostic Safety

new

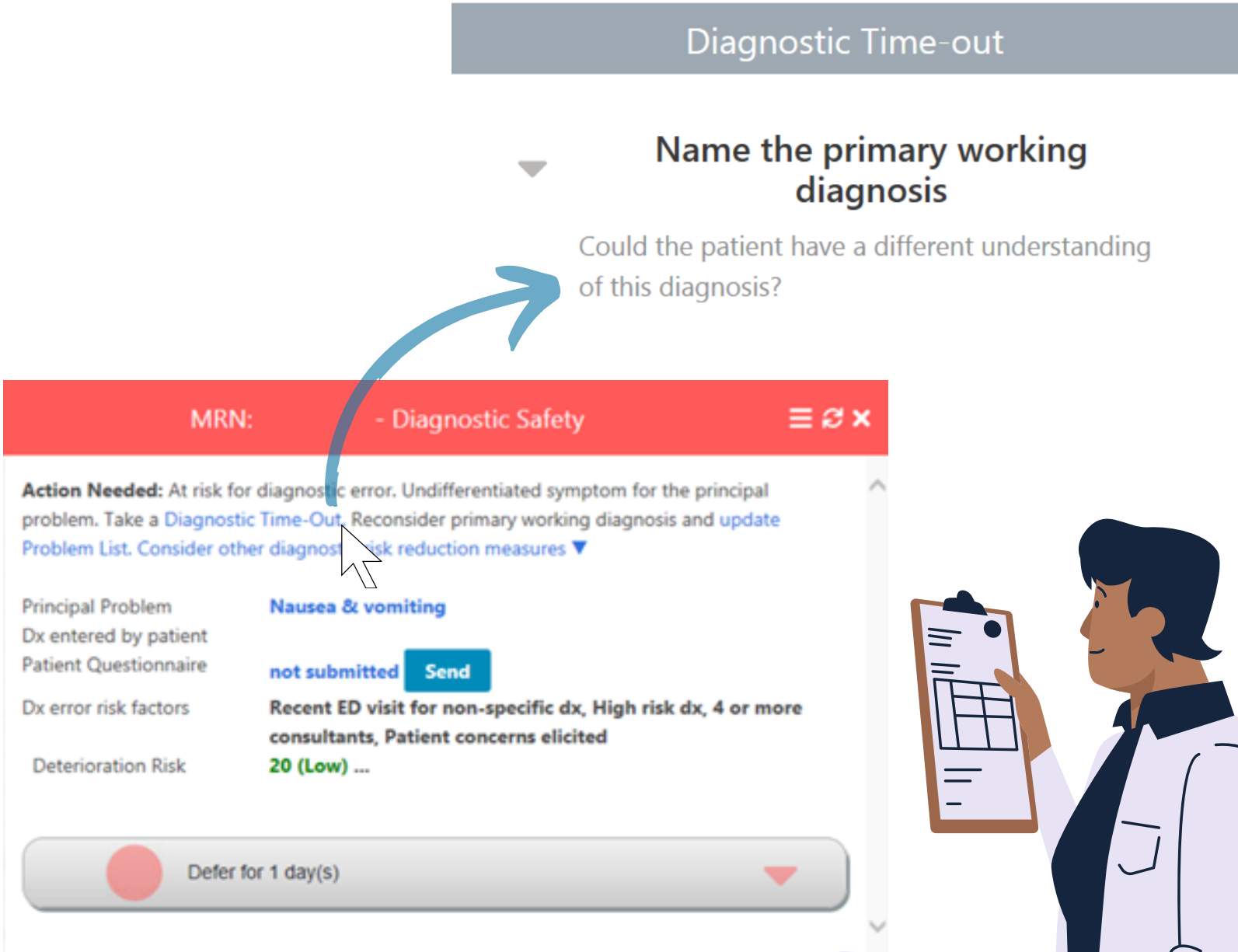
new


By "wrenching in" the Dashboard, it will now be accessible to you within one click!

# Featured Column: Diagnostic Safety

As a part of our diagnostic safety study, we have developed and refined a Diagnostic Safety column that enables you to:

- Identify patients at risk for diagnostic error
- Take a Diagnostic Time-Out
- Update the hospital Principal Problem
- View the patient's Deterioration Risk (EDI)
- View responses of patients who completed a Diagnostic Questionnaire (a 10-item survey that assesses patient's understanding and related concerns of their diagnosis, administered by our research team)

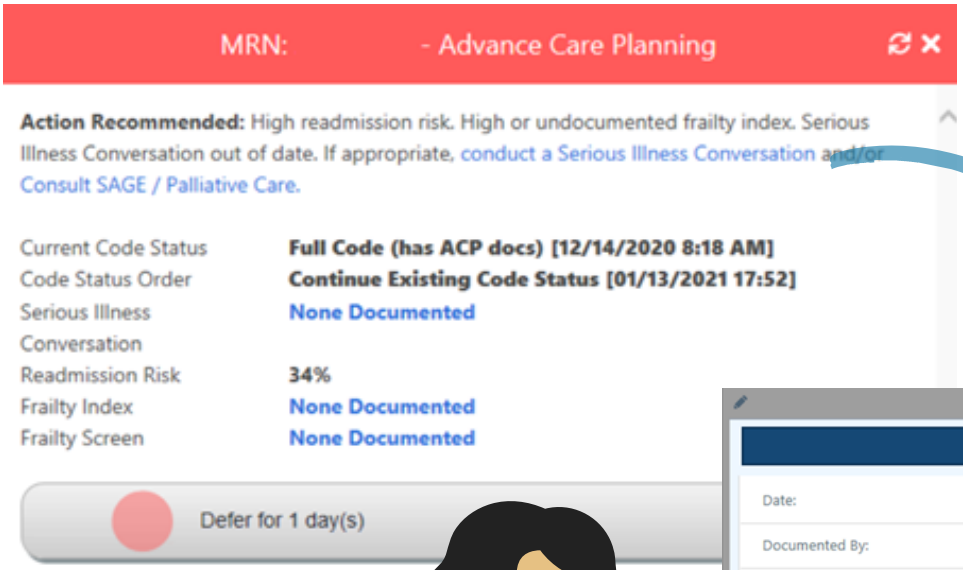


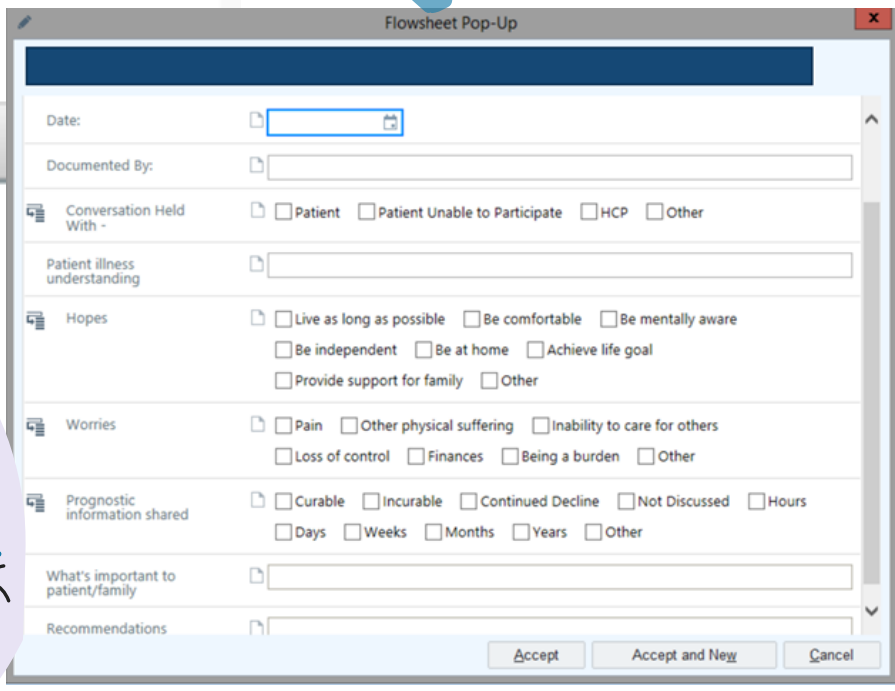
# Featured Column: Advanced Care Planning

Serious Illness Conversations (SICs) help provide our patients with goal concordant care and improves patient and family satisfaction. The Advanced Care Planning tool brings attention to patients who may benefit from a SIC, such as those with the following criteria:

- High readmission risk (>28%)
- High Frailty Index (>0.3)
- Undocumented Code Status
- Links to previously documented SICs

Click “conduct a Serious Illness Conversation” to document a new conversation. To pull in the most recent documented SIC into your note, use the **.SIC** dot phrase.



# Case of the Month

**Case summary**

91 y/o female with pulmonary hypertension, HFpEF, and BLE chronic venous stasis with recent discharge from rehab presenting after being found down at home. The patient reportedly tripped on a blanket upon standing. In the ED, her exam was notable for stable vitals (orthostatics were not performed), a systolic murmur, and 2+ edema of BLE. Labs, CT head and CXR were unremarkable. UA +nitrates/leukocytes. Received Fosfomycin x 1 dose. The primary working diagnosis was fall, likely mechanical with "multiple risk factors for impaired mobility and balance and likely insufficient care support at home." The initial plan was to obtain a PT consult and to hold Lasix and metoprolol that the patient was taking.

On HD#2, the pharmacy med rec team noted that the patient had been taking three anti-hypertensives at home over the past week (enalapril, Lasix, and metoprolol, which was not elicited upon admission); however, Lasix and metoprolol were discontinued during her prior rehab admission. Hypotension from polypharmacy was subsequently considered as a likely mechanism for fall. The hospital course was complicated by dehydration, AKI and hyperkalemia. Enalapril was stopped and IVF boluses were administered, while continuing to hold Lasix and metoprolol. Her blood pressures improved. Upon discharge, the primary diagnosis was fall: polypharmacy (hypotension from meds) vs mechanical with insufficient home care.

**Description of diagnostic error:**

- Failure to perform a complete medication reconciliation upon presentation to the ED and hospital admission. The patient continued to take Lasix and metoprolol despite these being discontinued during the prior rehab admission.
- If a full medication reconciliation was performed, ideally by a pharmacist in the ED, the team may have considered polypharmacy resulting in iatrogenic hypotension sooner and may have also considered holding Enalapril (in addition to Lasix and metoprolol).
- At time of admission, a primary working diagnosis of mechanical fall was over-weighted. Fall due to orthostatic hypotension was not considered in the differential in context of an incomplete medication history.
- Orthostatic vitals not performed at the time of admission in an elderly patient with multiple risk factors and an admission diagnosis of fall with unclear etiology.

**Outcome**

After a thorough medication reconciliation was performed on HD #2, the team more heavily weighed polypharmacy leading to hypotension as the mechanism for fall.

- Most significant failures in the diagnostic process
- Framing bias & premature closure – elderly patient presented after recent rehab admission after being found down at home, framed as mechanical fall due to unstable gait/balance. A workup for other etiologies, including polypharmacy, was delayed or not considered.
- Incomplete history gathering – a thorough med rec was delayed in this elderly patient with a recent rehab encounter. Important medication changes across care transitions are common. It was not clearly recognized that the patient had continued to take the discontinued medications.

**Harm**

Moderate. In addition to fall, the patient experienced hypotension, hypovolemia, and AKI, which likely increased length of stay.

Risk factors for diagnostic error

- Polypharmacy in elderly
- Incomplete medication reconciliation
- Recent rehab encounter, 1 week prior to presentation

**Lessons learned**

- Understaffing in the ED could have contributed to an incomplete medication reconciliation.
- Performing a full medication history is especially important for elderly patients with risk factors for polypharmacy, recent care transitions/facility encounters during which medications could have been adjusted.
- Consider taking a "Diagnostic Time Out" when confronted with an undifferentiated admission diagnosis for the hospital Principal Problem.

**If you would like to provide a Case of the Month for our next newsletter, we'd love to hear from you!**

# How can YOU improve quality and safety?

- Review the Quality and Safety Dashboard from the patient's chart when writing your notes
- All items in the "Safety Bundle" at the end of H&P's and progress notes are mirrored in the Dashboard, making this an optimal time for review
- Review the Dashboard with your residents, interns and/or APPs when running the list at the end of the day
- Conduct Diagnostic Time-Outs to address diagnostic uncertainty
- Prioritize patients who may benefit from a Serious Illness Conversation

**Download our Diagnostic Time-Out here:**

**Attend our Diagnostic Safety Workshops to learn more!**

**Keep an eye out for our weekly emails as you are coming onto your rotation or service! Users are also featured in our weekly usage reports! Thanks!**

## Contact Us!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